Appendix D: Service Authorization for DD Waiver Services

Last Updated: 05/16/2022

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General Information Chapter for Service Authorization - INTRODUCTION

Service authorization (SA) is the process to approve specific services for an enrolled Medicaid individual.

Service authorization must occur prior to service delivery (other than crisis services) and reimbursement.

Purpose of Service Authorization (DD Waiver Appendix D)

The purpose of SA is to validate that the service requested is needed by the individual and meets DMAS's criteria for reimbursement. All requests for SA must be submitted to DBHDS by the individual's support coordinator (SC) through the DBHDS Waiver Management System (WaMS).

SA does not guarantee payment for the service; payment is contingent upon service delivery, passing all edits contained within the claims payment process in MES (previously in VAMMIS), the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing necessity for the service. SA is specific to an individual, a provider, a service code, an established quantity of units/hours, and for specific dates of service. SA is performed by DBHDS or by a contracted entity.

General Information Regarding Service Authorization (DD Waiver)

Submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for SA requests.

The Service Authorization will:

Approve	An approval for services is rendered when the request for service authorization meets all waiver criteria as contained in the CMS Medicaid Waiver Application and the DD Waiver Regulations [12VAC30-122-10 - 570].
Approved-Modified	A service authorization request may be approved and modified (which results in appeal rights) based on lack of timeliness of submission, services requested were not justified, or services requested did not meet DD Waiver criteria.
Pend for Add'l Information	If additional information is needed from the provider, the service authorization request will be pended. DBHDS will limit the number of pended responses to two for any given request and will approve or deny that request on the third submission, unless there are mitigating circumstances that warrant reconsideration by the DD Waiver Manager and a final disposition will be rendered. If the SC or Provider cannot supply the information requested, the SA request will be rejected or denied by DBHDS with a note in WaMS documenting the reason for this action.
Reject	SA requests that do not meet specific data or basic formatting requirements and cannot be processed by Medicaid will be rejected. When a request is rejected, the earliest start date is date of resubmission of a new SA request via WaMS.
Deny	A denial of waiver services (which results in appeal rights) occurs when the individual or elements of the SA request do not meet the DD Waiver criteria in 12VAC30-122-10 – 570 and does not comport with the DD Waiver Manual's policies and procedures. When a request is denied, the earliest start date is the date of resubmission of a new SA request via WaMS.

Standard Definitions - Semi-Predictable Events / DAY SERVICES

Semi-predictable events include, but are not limited to, events such as illness, inclement weather resulting in the closing of day service sites, holidays, individual choice, etc. If a day services provider provides two or more of the following services to an individual (Group Day, Community Engagement, Community Coaching) and flexibility is required to accommodate individual choice and preference and/or inclement weather, etc., then the provider may request additional hours to their SA request for the combination of these services.

The provider may request up to 10 additional hours of day services per week that will allow the individual to choose additional community outings. These hours should be proportional to the overall requested amount of day services. In no circumstances can the additional hours total more than 66 hours per week. The request must include the reason for the additional hours and the provider must state that they understand that only services delivered will be billed. Attendance log and provider documentation must be maintained to verify service delivery. The service authorization staff will add

the additional hours provided to that month's authorized hours. Service authorization requests may be submitted after, but in the same month as service delivery.

Standard Definitions - Semi-Predictable Events / HOME-BASED

Semi-predictable events include, but are not limited to, events such as illness, inclement weather resulting in the closing of day or employment service sites, holidays, individual choice, etc. Individuals receiving In-home Support, Companion, or Personal Assistance services have various available natural supports, service provider resources, and are required to have back-up plans. Therefore, solutions for accommodating semi-predictable events will vary from person to person.

The back-up plan support should be considered as the first option to provide needed supports during semi-predictable events such as inclement weather, illness, etc. The back-up plan may, in some circumstances, involve the use of paid staff who substitute for those regularly scheduled or at times other than what may be regularly scheduled. However, there are times when a provider may anticipate a need for an increase in service hours due to holidays, doctor visits, etc. and the back-up plan is not an option. In these situations a provider may submit a service authorization request (if not already included in their annual plan request) that includes:

• The appropriate explanation such as clear notation of the insufficiency of the back-up plan, and

• Planned usage of additional hours and documentation of the supports that will be provided during those specific periods.

The service authorization staff will add the additional hours provided to that month's authorized hours. Service authorization requests may be submitted after, but in the same month as service delivery. Because these home-based services are authorized on a monthly basis, providers will have hours in that month's authorization on which to draw until the emergency request is made and approved. Only emergencies that occur on the last day of the month require a service authorization modification to be submitted that very day.

Changes in Medicaid Assignment (DD Waiver)

If an individual transitions between fee-for-service and the Medicaid Managed Care program, the following apply:

If the individual was eligible under fee-for-service (not Health Plan enrolled) for dates where the individual has subsequently become enrolled with a DMAS contracted Health Plan:

- The Health Plan will honor the Service Authorization contractor's SA based upon proof of authorization from the provider, DMAS, or the SA Contractor. SA decisions by the DMAS SA contractor are based upon clinical review and apply only to individuals enrolled in Medicaid fee-for-service on dates of service requested.
- The SA contractor decision does not guarantee Medicaid eligibility or fee-for-service enrollment. It is the provider's responsibility to verify individual eligibility and to check for

managed care organization (Health Plan) enrollment. For Health Plan enrolled individuals, the provider must follow the Health Plan's SA policy and billing guidelines for services covered through the Health Plan.

Communication (DD Waiver)

Provider manuals are located on the DMAS Web Portal https://www.dmas.virginia.gov/ and DBHDS website. The DBHDS website has information related to SA for programs identified in this manual. You may access this information by going to www.dbhds.virginia.gov. Updates or changes to the SA process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS Web Portal. Changes will be incorporated within the manual.

SA for the Developmental Disabilities Waivers – General Information

General Rules for all Services	• Enrollment of individuals seeking waiver services and support is performed by DBHDS. All requests for service authorization must be submitted to DBHDS by the individual's SC. Final determination of total hours/units/dollars cannot exceed the total hours/units/dollars approved by DBHDS. • When individual's needs or provider circumstances change (e.g., a need for a change in hours/units/dollars (increase or decrease), re-start after discharge, or transfer to a new provider), the SC must modify the Individual Support Plan (ISP) and ensure that the Plan for Supports or Interim Plan for Supports is provided by affected providers as appropriate. Requests via WaMS to revise previously approved authorization must be sent to DBHDS via the SC. Requests will include start and end dates along with explanation of need for modification and appropriate revision. • All services, other than Respite (which may be authorized for a 2-year timeframe), must be re-authorized at least every 12 months. • The authorized start date of services will not be prior to the date the SA request is initially submitted to DBHDS for eligible individual, except for crisis services. To assure the provider of individual eligibility and that services are authorized as requested, it is recommended that required documents be submitted at least 30 days prior to requested start of services. Requests for EPSDT Private Duty Nursing services for individuals on the DD waivers should be submitted at least 10 days, but no more than 30 days prior to requested service start or renewal date. All SA requests will be acted upon (i.e., review of the documentation to determine individual eligibility and the need for and appropriateness of the service being requested, followed by approval, denial, rejection, or pend for additional information) within 10 working days following receipt by DBHDS. Turnaround time begins at 12:01 a.m. on the date after the SC submits the request in WaMS. The timeframe does not include the entire span of time needed to process pended requests for additional information. Upon the receipt of a response to append, DBHDS has 10 additional business days to process the request. • Services will not be authorized when the provider of services is the parent or guardian of individuals enrolled in the waiver who are minor children, or in the case of an adult enrolled in the waiver, the adult individual's spouse. • Services will not be authorized for providers of services furnished by other family members living under the same roof as individual receiving services unless there is objective, written documentation as to why there are no other providers available to provide care. "Objective, written documentation" means documentation that demonstrates there are no persons available to provide supports to individual other than unpaid family/caregiver who lives in the home with the individual. See Chap. 2 for more details and examples. • At the time services are authorized, the notice to the provider will include both taxonomy and specialty code(s) required for billing.

Commonwealth Coordinated Care (Plus) Excluded Waiver Services

Commonwealth Coordinated Care Plus (CCC+) is a program for individuals with full Medicare and Medicaid benefits and meet all eligibility criteria; able to receive coordinated care through managed care environment. Program objective is to coordinate delivery of primary, preventive, acute, behavioral, and long-term care services and supports.

“CCC+ services do not cover the DD Waivers. If an individual becomes eligible for or receives a slot in one of these CCC+ excluded waivers, the individual will be enrolled in the Waiver and may begin receiving Waiver services. CCC+ will continue to cover the regular medical services until the end of the month. The individual will be automatically dis-enrolled from CCC+ the last day of that month.

The individual will receive all services through fee-for-service Medicaid or Medicare effective the first day of the next month.

The DMAS service authorization agent will process the service authorization request for the specific waiver services listed for individuals dually enrolled in CCC+. The request must include all the required documentation for a complete service authorization review. Providers will need to adhere to the timeliness requirements for new admission requests.

CCC+ also includes the CCC+ Waiver for those who qualify. The Continuity of Care Service Authorization affects all individuals receiving Personal Assistance in the CCC+ waiver and transitioning to the FIS or CL waivers. When a CCC+ waiver member is transitioning from the CCC+ waiver to a DD Waiver, DD Waiver enrollment, service authorizations and services cannot begin earlier than the first day of the month after the month in which CCC+ waiver service authorization ended. The Continuity of Care Service Authorization transition plan procedure was implemented on 12/30/2019.

Developmental Disabilities Waiver Services (BI/FIS/CL) Requiring Authorization

All requests must be submitted to DBHDS via WaMS by the individual’s SC. The ISP must include all required documentation for the requested service(s) and be approved by DBHDS prior to submitting claims to the
MES (previously in VAMMIS).

Proc. Code T1999	**Mod. N/A**	**Waiver BI, FIS, CL**	**Assistive Technology ONLY**
_____	**_____**		**_____**
Proc. Code T1999	**Mod. U5**		**Assistive Technology – Maintenance Cost ONLY**

Unit of service = Maximum Medicaid funded expenditure is $5,000.00 per calendar year for all AT – multiple items may be approved up to plan year limit.

Units are requested as “1” with straight cost amounts entered in WaMS. No calculation is required. The Service Authorization is entered for a 30 day time period within the calendar year.

AT is available to individuals receiving at least one other qualifying waiver service.

Proc. Code	Mod.	Waiver	Benefits Planning
T1023	N/A	BI, FIS, CL	

This service results in the development of written resource documents to assist individuals and their families/legal representatives to better understand the current and future benefits of working, thereby reducing ambivalence about losing necessary supports and benefits if they choose to work or stay on the job.

This service enables individuals to make an informed choice about the initiation of work. This service also provides information and education to working individuals to make successful transition to financial independence.

Providers may not request service authorization/bill for waiver Benefits Planning services while the eligible individual has an open employment services case with DARS and is eligible for this through DARS.

This service may be authorized one time per allowable activity per individual per calendar year. However, a service may be reauthorized within a calendar year if the individual's situation has changed in terms of disability conditions, benefit type, or employment status.

The annual calendar year limit for this service is $3,000. Unspent funds from one plan year may not be accumulated and carried over to subsequent plan years.

Activity & Hourly Limit per Activity:

- Plan for Achieving Self-Support-Part 1 hours - 7.0
- Plan for Achieving Self-Support-Part 2 hours - 12.5
- Impairment Related Work Expense hours - 9.0
- Blind Work Expense hours - 9.0
- 1619(b) Medicaid hours - 4.0
- Student Earned Income Exclusion hours - 9.0
- Subsidy hours - 9.0
- Work Activity Reports hours - 6.0
- Medicaid Works hours - 5.5
- Overpayment hours -3.5
- Benefits Planning Query hours - 1.0
- Pre-Employment BSA hours -7.0
- WorkWORLD Summary and Analysis hours -7.0
- Individual Development Accounts hours -7.0
- Section 301/Able Now hours - 4.5
- Financial Health Assessment hours - 3.5
- WI Revisions hours -7.0

Proc. Code	Mod.	Waiver	Center-Based Crisis Supports (PROFESSIONAL)
H2011	U1	BI, FIS, CL	
_____	_____		_____
H2011	UA		Center-Based Crisis Supports (NON-PROFESSIONAL)

Unit of service = 1 hour. This service may be authorized up to 72 hours after the QDDP face- to-face assessment or reassessment.

Service must be limited to six months per ISP year and must be authorized in increments of up to a maximum of 30 days with each authorization.

The service authorization request should include documentation that the individual has a history of at least one of the following:
• Psychiatric hospitalization(s);
• Incarceration;
• Residential/day placement(s) that was terminated; or
• Behavior(s) have significantly jeopardized placement.

Also, the individual must meet at least one of the following:
- Experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning;
- Experiencing an increase in emotional distress;
- Needs continuous intervention to maintain stability; or
- Causing harm to himself or others.

The individual must also be:
- At risk of psychiatric hospitalization;
- At risk of emergency ICF/IID placement;
- At immediate risk of loss of community service due to severe situational reaction; or
- Actually causing harm to him/herself or others.

The ISP Parts 1-4 are to be submitted by the SC in WaMS with supporting documentation/justification for this service – the Part 5 is not required for Center-Based Crisis Supports.

Proc. Code S9484 Eff. 7/01/21	**Mod. U1**	**Waiver BI, FIS, CL**	**COMMUNITY-Based Crisis Supports (PROFESSIONAL)**
S9484 Eff. 7/01/21	**N/A**		**COMMUNITY-Based Crisis Supports (NON - PROFESSIONAL)**

Unit of service = 1 hour. This service may be authorized up to 72 hours after the QDDP face- to-face assessment or reassessment.

Service may be authorized for up to 24 hours per day, if necessary, in increments of no more than 15 days at a time.

The annual limit is 1080 hours. Requests for additional hours in excess of the 1080 limit will be considered if justification of the individual need is provided. The service authorization request should include documentation that the individual has a history of at least one of the following:

• Previous psychiatric hospitalization or hospitalizations;
• Previous incarceration;
• Lost previous residential/day placement or placements; or
• His behavior or behaviors have jeopardized his community placement.

Meets at least one of the following:
• Is experiencing a marked reduction in psychiatric, adaptive, or behavioral functioning;
• Is experiencing an increase in extreme emotional distress;
• Needs continuous intervention to maintain stability; or
• Is actually causing harm to himself or others.

And Also:
• Is at risk of psychiatric hospitalization;
• Is at risk of emergency ICF/IID placement; and/or
• Is at immediate threat of loss of community service due to a severe situational reaction.
• Actually causing harm to self or others.

In addition, the SA request must include documentation that an assessment/re-assessment by a Qualified Developmental Disabilities Professional (QDDP) was performed.

The ISP Parts 1-4 are to be submitted by the SC in WaMS with supporting documentation/justification for this service. The Part V is not required for this service.

Proc. Code	Mod.	Waiver	Community Coaching
T2013	N/A	BI, FIS, CL	

Unit of service = 1 hour. The expected number of weekly units of services are requested and authorized in monthly totals.

These services, either alone, or in combination with any of the following services: individual and/or group supported employment services, community engagement, group day, and/or workplace assistance must be limited to 66 hours per week.

An initial 60-day assessment plan may be submitted. Prior to the last day of the assessment period, an annual Plan for Supports must be submitted for continued authorization. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual ISP.

The maximum service authorization duration is 12 months, and in accordance with ISP's effective from and through dates. The ISP Parts 1-4 and the provider's Part 5 are to be submitted by the SC in WaMS with supporting documentation/justification for this service. Justification should include a description of the specific barrier(s) currently being encountered to support this 1:1 service vs. utilizing Community Engagement.

Services will be provided in the community. A schedule of supports identifying community activities/events should be provided. The Part V should include skill building in relation to specific barriers. The barriers should be clearly identified.

For Semi-Predictable Events / DAY SERVICES please refer to Standard Definitions (p.2).

Proc. Code	**Mod.**	**Waiver**	**Community Coaching (CUSTOMIZED)**
T2013	**U1**	**BI, FIS, CL**	
PLEASE REFER TO MEDICAID MEMO DATED 9/1/2017 FOR ALL INFORMATION PERTAINING TO CUSTOMIZED RATES.			
Proc. Code	**Mod.**	**Waiver**	**Community Engagement**
T2021	**N/A**	**BI, FIS, CL**	

Unit of service = 1 hour. The expected number of weekly units of services are requested and authorized in monthly totals. These services, either alone or in combination with any of the following services: individual and/or group supported employment services, group day, community coaching and/or workplace assistance must be limited to 66 hours per week. A menu of supports identifying community activities/events should be provided.

For Semi-Predictable Events / DAY SERVICES please refer to Standard Definitions (p.2).

An initial 60-day assessment plan may be submitted. Prior to the last day of the assessment period, an annual Plan for Supports must be submitted for continued authorization. The start date of the annual Plan for Supports must be no later than day 61 and the end date must correspond to the end date of the annual ISP.

The maximum service authorization duration is 12 months, and in accordance with the ISP's effective from and through dates. The ISP Parts 1-4 and the provider's Part 5 are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

Proc. Code	Mod.	Waiver	Community Guide
H2015	N/A	BI, FIS, CL	

Unit of service = 1 hour.

There are two types of Community Guide.

General community guide:
This involves utilizing existing assessment information regarding the individual's general interests in order to determine specific preferred activities and venues that are available in his community to which he desires to be connected (e.g., clubs, special interest groups, physical activities/sports teams, etc.) in order to promote his inclusion and independent participation in the life of his community. The desired result is an increase in daily or weekly natural supports, as opposed to increasing hours of paid supports.

Community housing guide:
This involves supporting an individual's move to independent housing by helping with transition and tenancy sustaining activities. The community housing guide must work in collaboration with the SC, regional housing specialist, and others to enable the individual achieve and sustain integrated, independent living.

Community Guide is expected to be a short, periodically intermittent, intense service associated with a specific outcome. The plan for supports should delineate which type of community guide is being requested.
An individual may receive one or both of the two types of Community Guide services in an ISP year.

Each type of Community Guide service may be authorized for up to 6 consecutive months, and the cumulative total across both may be no more than 120 hours in a plan year.

Community Guide activities conducted not in the presence of the individual, such as researching and contacting potential sites, supports, services and resources, must not comprise more than twenty-five percent of authorized plan for support hours.

The Community Guide must not supplant, replace, or duplicate activities that are required to be provided by the SC.

Prior to accessing funding for this service, all other available and appropriate funding sources must be explored and exhausted.

The ISP Parts 1-4 and the provider's Part 5 are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

Proc. Code	Mod.	Waiver	Agency-Directed Companion Services
S5135	N/A	FIS, CL	

Unit of service = 1 hour. Services are requested weekly and authorized in monthly unis. A maximum of 8 hours per 24 hour day (or 2920 hours per ISP year) may be authorized for this service per ISP year, either singly or for both types of Companion services combined.

May only be authorized for individuals 18 years and older.

Documentation submitted with the service authorization request must confirm that the service is not purely recreational in nature.

Service must not be authorized to include the provision of nursing care procedures including care of ventilators, tube feedings, suctioning of airways, external catheters, or wound care nor must it include the provision of routine support with ADLs (may be provided PRN). Hours authorized must be based on the documented need of the individual. This service does not include skill building.

A back-up plan must be identified in the event the companion cannot provide services to the individual.

For Semi-Predictable Events / HOME-BASED please refer to Standard Definitions (beginning on p.2).

For an individual receiving group home, sponsored residential or supportive living services, Companion services will not be authorized to be delivered by an immediate family member.

For an individual receiving sponsored residential services, Companion services will not be authorized to be delivered by a member of the sponsored family residing in the sponsored residential home.

The maximum service authorization duration is 12 months, and in accordance with the ISP's effective from and through dates. The ISP Parts 1-4 and the provider's Part 5 are to be submitted by the SC in WaMS with supporting documentation/justification for this service.

Proc. Code	**Mod.**	**Waiver**	**Consumer-Directed Companion Services**
S5136	**N/A**	**FIS, CL**	

Unit of service = 1 hour; requested hours/week is multiplied by 2 and approved in bi-weekly units. A maximum of 8 hours per 24-hour day (or 2920 hours per ISP year) may be authorized for this service per ISP year, either singly or for both types of Companion services combined.

May only be authorized for individuals 18 years and older.

Documentation submitted with the service authorization request must confirm that the service is not purely recreational in nature.

Service must not be authorized to include the provision of nursing care procedures including care of ventilators, tube feedings, suctioning of airways, external catheters, or wound care nor must it include the provision of routine support with ADLs (may be provided PRN). Hours authorized must be based on the documented need of the individual. This service does not include skill building.

A back up plan must be identified in the event the companion cannot provide services to the individual.

Any combination of respite service, personal assistance service, and companion service must be limited to 56 hours per week for a single employer of record (EOR) by the same companion. Companions who live with the individual, either full time or for substantial amounts of time, must not be restricted to only 56 hours per week for the single EOR.

The companion must not provide more than 16 hours of consumer-directed services per day. The 16- hour limit must include hours worked in one day providing a combination of companion, personal assistance, and respite services.

All CD services require the services of a Services Facilitator or that an unpaid person (such as a family member) acts in this capacity. If the individual is not going to direct his own services, an EOR must be identified.

Family/caregivers acting as the employer on behalf of the individual (EOR) may not also be the CD employee.
For an individual receiving group home, sponsored residential or supportive living services, Companion services will not be authorized to be delivered by an immediate family member.

For an individual receiving sponsored residential services, the companion must not be a member of the sponsored family residing in the sponsored residential home.

The maximum service authorization duration is 12 months, and in accordance with the ISP’s effective from and through dates. The ISP Parts 1-4 and the Part 5 or a Personal Preference tool with a DMAS 97, the DMAS 99, and a schedule are to be submitted by the SC in WaMS with supporting documentation/justification for this service.